

# TheUpshot.*Online*

A publication of the Texas Department of State Health Services Immunization Branch

## Immunization Branch Katrina Activities

By Victoria Brice, Immunization Branch

### Emergency Response

The Department of State Health Services (DSHS) Immunization Branch quickly responded to the vaccine and vaccine distribution needs of hurricane Katrina evacuees and public health workers. An early and ongoing collaboration with Public Health Regional offices produced an expanded depot strategy, streamlined provider vaccine processes, and customized existing Immunization Branch systems to support the emergency public health needs. Efforts and communications were coordinated through existing partnerships with the Texas Education Agency, Texas Nurse Association, Texas School Nurse Organization, and others. The overarching theme of HUG, HELP, SERVE, and TRACK provided by Dr. Sanchez was the foundation for streamlining decisions.

Determining which vaccines to recommend for evacuees and public health workers was based on DSHS recommendations and the Centers for Disease Control (CDC) extensive guidance. Early assessment of vaccine needs based on shelter capacities, shelter population details, and regional feedback provided the foundation for expedited vaccine ordering efforts and vaccine funding. DSHS was able to deliver recommended vaccines guidance and vaccine distribution strategies within forty-eight hours of the requests.

### Provisional School Enrollment

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While distribution activities were underway, the Immunization Branch issued a temporary 30-day provisional enrollment for displaced children. Getting children enrolled in Texas schools under temporary provisional enrollment established a usual routine in the displaced children's extremely unusual and perhaps frightening evacuation experience. A DSHS Vaccine Records Call Center, which accesses existing Louisiana Immunization Registry information, was established in mid-September. Limited direct access to the Louisiana Registry was coordinated through the Texas Immunization Registry (ImmTrac).

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## Influenza Vaccine Updates

Compiled by Lisa Davis, CDC Consultant

### Medicare Reimbursements for Influenza and Pneumococcal Vaccines

The 2005-06 Medicare influenza and pneumococcal reimbursement rates have been published. Below is the link to the latest Medicare Influenza Bulletin from Trailblazer Health. Trailblazer Health is the state Medicare carrier. Please note that paper roster billing will be acceptable for this influenza vaccination season. The roster billing forms are included in the bulletin. <http://www.trailblazerhealth.com/pub/partb/all/2005/05-055.pdf>

#### 2005 Medicare Vaccine Reimbursement:

Flu vaccine, 6-35 months	\$13.68
Flu vaccine, 3 yrs and older	\$10.10
Pneumococcal , adult	\$24.57

#### 2005 Medicare Administration Reimbursement:

##### County code

09	Brazoria	\$18.37
11	Dallas	\$19.40
15	Galveston	\$18.21
18	Harris	\$18.93
20	Jefferson	\$17.21
28	Tarrant	\$18.42
31	Travis	\$18.81
99	Rest of State	\$17.13

**Note:** If your county is not listed specifically, then you are in Locality 99 - Rest of State. ♦

### Update: Influenza Vaccine Supply and Recommendations for Prioritization During the 2005—06 Influenza Season

Reprinted from MMWR: September 2, 2005 / 54(34);850

Influenza vaccine distribution delays or vaccine supply shortages have occurred in the United States in three of the last five influenza seasons (1,2). In response, prioritization has been implemented in previous years to ensure that enough vaccine is available for those at the highest risk for complications from influenza (3). The information in this report updates projections of influenza vaccine supply and previous recommendations for priority use of trivalent inactivated influenza vaccine (TIV) during the 2005—06 influenza season (4).

Four manufacturers now expect to provide influenza vaccine to the US population during the 2005—06 influenza season (See table, page 4). Sanofi Pasteur, Inc., projects production of 60 million doses of TIV. Chiron Corporation projects production of fewer than 18 million doses of TIV. GlaxoSmithKline (GSK), Inc., whose license application was approved by the Food and Drug Administration on August 31, 2005, projects production of

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8 million doses of TIV. MedImmune Vaccines, Inc., producer of live attenuated influenza vaccine (LAIV), projects production of approximately 3 million doses.

Because of the uncertainties regarding production of influenza vaccine, the exact number of available doses and timing of vaccine distribution for the 2005--06 influenza season remain unknown.

## References

1. CDC. Updated recommendations from the Advisory Committee on Immunization Practices in response to delays in supply of influenza vaccine for the 2000—01 season. MMWR 2000;49:888—92.
2. CDC. Delayed influenza vaccine availability for 2001—02 season and supplemental recommendations of the Advisory Committee on Immunization Practices. MMWR 2001;50:582—5.
3. CDC. Interim influenza vaccination recommendations, 2004—05 influenza season. MMWR 2004;53:923—4.
4. CDC. Tiered use of inactivated influenza vaccine in the event of a vaccine shortage. MMWR 2005;54:749—50.
5. CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2005;54(No. RR-8). ♦

# Vaccine Services *Updates*

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## Record Highs in August

By Charlotte Hunter, Vaccine Services Group



In August, the Texas Vaccine For Children Program (TVFC) shipped out a record 1,033,881 doses of vaccine to enrolled providers. With the inclusion of combination vaccines, the TVFC has begun to see fewer doses shipping out. However, that trend was bucked this past August.

Reasons that contributed to this record setting month include the new legislation requirements for childcare and pre-kindergarten entrance as well as the general back-to-school rush. With providers scheduling back-to-school clinics throughout the state, the TVFC has been busier than ever.

With hard work and dedication, TVFC staff throughout the state were able to take this task head-on and meet the increased demand. With the back to school rush now behind us, we say, "Bring on the flu season!"

For more information, please contact your TVFC Consultant at 800-252-9152 or 512-458-7284. ♦

## Texas Vaccines for Children (TVFC) Program 2005-06 Inactivated Influenza Vaccine Dosages

Product Name	Age	Dosage	Formulation <sup>a</sup>	Number of Doses	Route
FluZone®PF	6 through 35 months	.25 mL	Preservative-free Pre-filled syringe Pediatric Dose	1 or 2 <sup>b</sup>	Intramuscular
FluZone®	3 through 8 years	.50 mL	10 dose vials	1 or 2 <sup>b</sup>	Intramuscular
FluZone®	9 years and older	.50 mL	10 dose vials	1	Intramuscular

<sup>a</sup> Refer to package insert for instruction.

<sup>b</sup> Two doses are recommended for children under 9 years of age who are receiving influenza vaccine for the first time. Administer at least one month apart, and, if possible, give second dose before December.

The FluZone®PF by Sanofi Pasteur is the recommended vaccine for children ages 6 through 35 months. FluZone® is preferred for children three years old and older. All vaccines prepared for the 2005-06 season, inactivated and live attenuated, will include antigens to protect against A/California/7/2004 (H3N2)-like, A/New Caledonia/20/99 (H1N1)-like, and B/Shanghai/361/2002-like antigens.

The Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices states that the optimal time to vaccinate those at risk for complications is usually during October and November. TVFC influenza vaccine orders should be placed beginning in September and will continue through the vaccination season (October through March). When ordering, please consider the number of patients you expect to see monthly and order appropriately.

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## TVFC Children Eligible for Inactivated Influenza Vaccine

CDC recommends that only the following priority groups receive influenza vaccine before October 24, 2005:

- Children aged 6 months through 23 months.
- Children and adolescents aged 6 months through 18 years with chronic disorders of the pulmonary or cardiovascular system, including asthma.
- Children and adolescents aged 6 months through 18 years who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic disease (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medication or human immunodeficiency virus [HIV]).
- Children and adolescents aged 6 months through 18 years who are receiving long-term aspirin therapy and may therefore be at risk for developing Reye's Syndrome after influenza.
- Children and adolescents aged 6 months through 18 years who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration.
- Children and adolescents aged 6 months through 18 years who are residents of nursing homes and other chronic-care facilities that house persons at any age who have chronic medical conditions.
- Females under 19 years who will be pregnant during the influenza season.
- Children and adolescents aged 6 months through 18 years displaced by Hurricane Katrina and living in a crowded group setting ( $\geq 100$  people).
- Children and adolescents aged 6 months through 18 years who are household contacts and out-of-home caregivers of children aged  $<6$  months.

Beginning October 24, 2005, influenza vaccine should be made available to:

- Children and adolescents aged 2 years through 18 years who are household contacts of persons in high-risk groups (e.g., persons aged 65 years or older, transplant recipients, persons with AIDS, and children aged less than 2 years).

For additional information, please contact your health service region or local health department. ♦

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## Targeted Media Campaign to Air this Fall

By: Alma Lydia Thompson, Public Information, Education, and Training Group

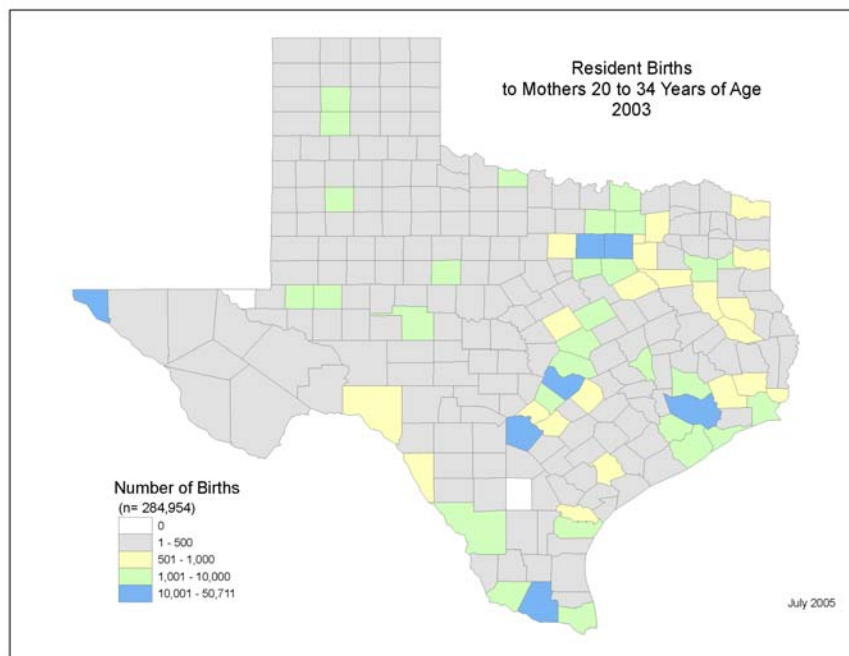
The 2005 immunization television and radio media campaign is scheduled to run in the San Antonio, Houston, Dallas-Ft. Worth, El Paso, and their outlying areas from November to December.

The campaign goal is to increase awareness among mothers of children under age 3 of the importance of vaccines as the foundation to the future good health of their children. The campaign is designed to build upon the branding initiated in the 2004 campaign.

The campaign strategy is to impress or “brand” the slogan/logo “Vaccines: Build Your Child’s Health” into the minds of mothers of children under age 3 in the selected media markets. This effort should prompt a response from the mothers to address their children’s immunization needs and check to make sure their children are up-to-date on receiving their vaccinations. The goal is to increase vaccine coverage levels.

The TV and radio campaign will be done with existing creative advertising concepts and messages used in 2004. The campaign will reinforce the message that vaccines are safe and effective in preventing disease. This year, grassroots public relations efforts will complement and enhance the campaign to encourage parents to stay up-to-date on their children’s vaccines. Public relations efforts consist of activities and events planned to keep the organization’s mission and purpose at the forefront of the public’s mind. Public relations increases media interest and publicity, which, in turn, help to create community awareness. Public relations efforts are best done through third party endorsements (word-of-mouth). Therefore, grassroots activities are performed at the community level and led by local leaders and influential residents.

Interlex USA, the advertising agency under contract to the Department of State Health



Number of resident births to mothers 20 to 34 years of age per county in 2003, according to the US Census.



Services (DSHS), will make minor revisions to the radio and TV ads and complete these before launching the campaign. Last year, an evaluation report showed that the audiences targeted in the 2004 campaign preferred multicultural ads depicting children of all ethnicities. Selected footage in the existing ads will be changed to show several ethnicities in the advertisements that will be airing this year.

Initial planning for this campaign included geomapping based on the 2003 Census, which indicated the locations for the highest resident births in Texas, along with the race/ethnicity and ages for the largest groups of women giving birth in the state. The Immunization Services and Data Coordination Group created tables from Census data and worked with the Center for Health Statistics staff to develop maps depicting the areas across the state with the highest number of births. Staff from the Immunization Branch Public Information, Education, and Training Group used these numbers and maps to determine the cities, the media, and programming for the campaign.

Several factors were considered during the selection of the cities for the campaign, including highest number of resident births,

lower branding effects of the previous campaign, demographics, market costs, radio and TV signal coverage, and the Immunization Branch's media budget.

Evaluation is a critical component in the planning and execution of this campaign. SUMA/Orchard Social Marketing, Inc., the research company under contract to DSHS, will perform an independent evaluation. They will conduct surveys before and after the campaign in two of the cities for each target audience chosen. Through a random-digit dial survey in each city where the ads will be shown, SUMA will call more than 450 mothers with children under the age of three—including 100 Spanish-speaking women—and ask them to complete a phone questionnaire regarding the advertising campaign. Questions include where the mothers viewed or heard the ads, recall on the message, and whether the ads prompted a response, such as whether the ads motivated them to check if their child was up-to-date on their vaccinations.

The documentation of the planning, research, and evaluation involved in determining the effectiveness of the campaign will help guide decisions for future educational projects and campaigns. ♦

Ranking	Residence County	Total
	<b>Texas</b>	<b>377,374</b>
1	Harris County	66,707
2	Dallas County	42,297
3	Tarrant County	27,574
4	Bexar County	24,927
5	Hidalgo County	16,233
6	Travis County	14,531
7	El Paso County	14,201
8	Collin County	10,168
9	Denton County	8,607
10	Cameron County	8,588
	<b>10-County Total</b>	<b>233,833</b>

Ranking of residence birth by county in 2003, according to the US Census. Cities selected for the campaign were chosen from among those located in the 10 counties with the highest resident births.

# Community *Partnerships*

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## Texas Immunization Stakeholder Working Group Celebrates One Year!



Pictured left to right: Claude Longoria, DSHS, Karen Hess, DSHS, Jean Hanson, DSHS, Pat Feagin DSHS, Robin Scott, DSHS, Linda Linville, TNA, Carrie Kroll, TPS, Jack Sims, DSHS Gayle Love, TMA, Kathy Moore, TALHO, Jason V. Terk, MD, TPS, Lupe Mandujano-Garcia, DSHS, Kim Robinson, TPA, Tom Cowan, TEA, Shelley Bjorkman, HHSC, Kathy Dryer, UNT, Decrecia Robinson, Houston Harris County Health Department, David Janicek, Wyeth, Victoria Brice, DSHS, Tim Hawkins, DSHS, Julia Irby, DARS, Anita Freeman, DSHS, Susan Nunnery DSHS, David Scott DSHS. Members and Staff not pictured Barry Lachman, MD, TAHP, Neil Levy, DO, TOMA, Dawn Richardson, PROVE, Raif Calvert, TAFP, Jesse Moss Jr., MD, NMA, Craig Tounget, TPTA, Elizabeth Sjorberg, THA, Beth Devery, TACHC and Vivian Harris, DSHS.

By: Vivian Harris, Services Data and Coordination Group

The Texas Immunization Stakeholder Working Group (TISWG) celebrated one year of success on August 18, 2005, in Austin, Texas. The TISWG was formed in a response to stakeholder recommendations and legislative mandates calling for partnerships and cooperation to raise vaccine coverage levels. Raising vaccine coverage levels for Texas children, as well as ensuring appropriate adult immunizations, is one of the highest priorities for the Department of State Health Services (DSHS). The Texas immunization system is complex and requires many partners from diverse backgrounds to address the many concerns of immunizations. The TISWG participants share ideas and resources, explore best practices, and offer recommendations to the DSHS Immunization Branch in seeking needed solutions to these concerns.

Core members of the TISWG have standing orders to attend every meeting and establish goals and include, the Department Assistive Rehabilitative Services, Early Childhood Intervention, the Texas Pediatric Society, the Texas Medical Association, the National Medical Association, the Texas Association of Health Plans, the Texas Academy of Family Physicians, the Texas Association of Local Health Officials, the Texas Education Agency, the Texas Parent Teacher Association, the Texas Pharmacy Association, the Texas Nurses Association, Parents Requesting Open Vaccine Education (PROVE), the Health and Human Services Commission, the Texas Hospital Association, the Texas Association of Community Health Centers, and the DSHS. To learn more about the TISWG goals and accomplishments, please visit our website at <http://www.tdh.state.tx.us/immunize/partners/tiswg.htm> or contact Vivian Harris, Partnerships Coordinator, at [Vivian.Harris@dshs.state.tx.us](mailto:Vivian.Harris@dshs.state.tx.us).

*Community Partnerships continued on page 14*



## ImmTrac, the Texas Immunization Registry: A Back-to-School Must

By: Adriana Rhames, ImmTrac Group

Back-to-school checklists for many Texas healthcare providers and school nurses now include “registering for ImmTrac access.” August is a busy month for schools, physicians, and other health care providers, when Texas schools reconvene for the fall semester. ImmTrac users and clients have realized the benefits of the Texas immunization registry and are increasingly turning to ImmTrac for back-to-school immunization records.

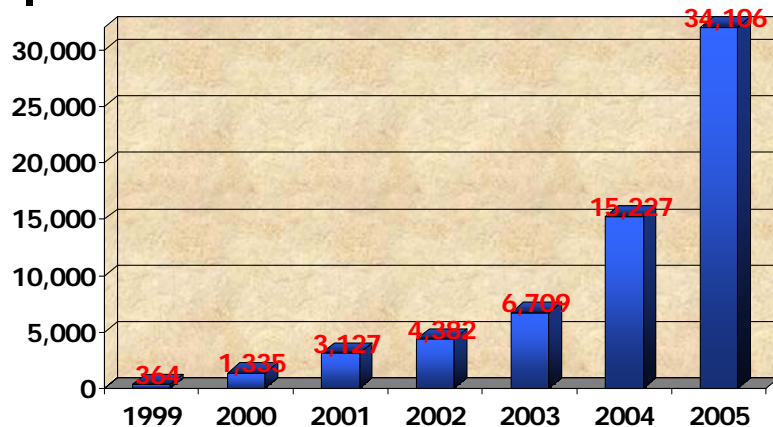
Recent statistics indicate a significant increase in use of the ImmTrac application for generation of immunization records for children throughout the state. During the August Back-to-School Rush, client immunization records generated from ImmTrac by ImmTrac users set a new record high in the history of the Texas immunization registry. During August 2005, ImmTrac produced more than 34,000 client immunization histories for participating Texas children. This number is more than double the August 2004 Back-To-School Rush total (15,227). Compared to August 2003 ImmTrac-generated immunization records (6,709), this year's figures have increased by more than 400%.

Offered by the Texas Department of State Health Services (DSHS), the state's confidential registry is available free of charge to all children and healthcare providers,

including school nurses. ImmTrac is designed to consolidate immunization records from multiple healthcare providers and store a child's immunization information electronically in one secure central system.

Currently ImmTrac contains over 47 million immunization records on more than 5 million

### **Back-To-School Rush** Immunization Histories Generated (August)



participating young Texans. Over 2 million ImmTrac clients are children under 6 years of age. ImmTrac also has nearly 3,500 registered user sites across the state, primarily physicians and schools nurses. Since January 1, 2005, ImmTrac Customer Support staff has added almost 1,100 new user sites. Additionally, thirty health plans have also registered for ImmTrac access and reporting capability.

“The phenomenal growth that ImmTrac has experienced demonstrates the usefulness of

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the registry for health care providers, schools, and parents,” said ImmTrac Group Manager Claude Longoria. “In ever-growing numbers, ImmTrac users are consulting ImmTrac to obtain their client’s most complete immunization history. This growth has been evident not only during the back-to-school rush, but throughout the year as well. As ImmTrac participation increases among physicians and other providers, the registry will deliver even greater benefits to users and Texas families.”

### **Benefits of ImmTrac**

By using ImmTrac, all healthcare providers, including school nurses, can access and review their clients’ immunization records and determine if the child is due or overdue for any immunizations. For physicians, ImmTrac also makes available a *reminder and recall* feature, allowing them the option of generating reminder and recall reports, letters, or labels for mailing out customized notices. Reports and

letters list any vaccines the child may be due or overdue, allowing the provider to communicate this information to the child’s parents. An ImmTrac-generated immunization record is recognized as an *official immunization record* for school and childcare attendance requirements.

Everyone benefits from ImmTrac and its useful features. The web-based ImmTrac registry application is very user-friendly, offering quick and easy immunization reporting and look up, helpful screen tips, an

online user manual, and phone and e-mail ImmTrac customer support options.

For parents, ImmTrac consolidates and safely stores their child’s immunization records. An official, state-issued immunization record for their child is available to them as often as needed, at no cost.

In addition, school nurses regard ImmTrac as a big time saver since most of their students’ records are conveniently accessible.

*“Had I not had ImmTrac, I would have required (the students) to get additional immunizations unnecessarily to bring them up to school compliance.”*

“I have recommended (ImmTrac) to every school nurse I have spoken with and who does not currently use ImmTrac,” said Jan Tomison, school nurse at Marble Falls Elementary School. Ms. Tomison began using ImmTrac in 2001 and continues to benefit from it in many ways. For her pre-kindergarten students, she uses ImmTrac to verify immunization records brought in by parents. “Oftentimes, the ImmTrac immunization record is

more complete than the records provided by the parents,” said Tomison. She explained that, in many cases, the parent simply forgot to take the shot record to the physician so the new immunization was not noted on the parent’s copy whereas the provider updated the child’s record in ImmTrac, allowing that information to be conveniently available to her.

Ms. Tomison also explained one situation that she often cites when voluntarily promoting ImmTrac to her peers and counterparts. Her experience involved two newly relocated

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students whose parent was unable to provide proper documentation for school enrollment. The parent informed Ms. Tomison that the children had received vaccinations through various Women, Infants, and Children (WIC) clinics across the state. After performing a search in the ImmTrac registry, Ms. Tomison was able to obtain records for the children.

“Had I not had ImmTrac, I would have required (the students) to get additional immunizations unnecessarily to bring them up to school compliance,” exclaimed Tomison.

“ImmTrac is meeting my needs right now. It is a valuable tool for me as a school nurse. It helps me do my job and helps me deal with parents and provide them the service of giving them one consolidated record,” added Tomison. “My goal is to get every student placed in ImmTrac... if everybody participated we would have a fantastic program.”

### **Current Legislation and ImmTrac**

ImmTrac receives immunization data from a variety of sources qualifying under the specifications of Texas law. Current state law requires that all healthcare providers report all vaccines administered to a child younger than 18 years of age to ImmTrac within 30 days of administration of the vaccine. All payors must report all immunizations for anyone under the age of 18 years on whom they pay a vaccine-related claim within 30 days of having received the claim information from a health care provider. ImmTrac also receives immunization data for participating clients from other sources including health plans, Medicaid, WIC, Children’s Health Insurance Plan (CHIP), and the DSHS Vital Statistics Unit.

Additionally, Texas law requires written parental consent for a child to participate in ImmTrac and that all parents of Texas newborns be given the opportunity to “grant”

or “deny” consent for ImmTrac participation during the birth registration process.

### **Authorized ImmTrac Users**

State law specifies the entities allowed access to registry data. Those with access include any physician or healthcare professional licensed to administer vaccines, schools, licensed childcare facilities, local health departments, public health districts, payors, and state agencies having legal custody of a child. Authorized entities can register to have convenient access to their patients’ and students’ immunization histories via the ImmTrac web application. A new parent can also receive a record of any ImmTrac data available for their child.

As in the case of Ms. Tomison, access to ImmTrac enables registered users to access, review, determine the need for immunizations, and to update the child’s immunization record.

To register for ImmTrac participation, please complete the ImmTrac registration packet by accessing the *ImmTrac Registration Packet for Providers and Schools* link from the registry’s website at: [www.ImmTrac.com](http://www.ImmTrac.com). Registration packets can also be obtained by calling the ImmTrac Customer Support at (800) 348-9158. For additional information about how ImmTrac can benefit your school and help protect Texas children, please contact Adriana Rhames at (512) 458-7111, extension 2924, or you may e-mail her at [Adriana.Rhames@dshs.state.tx.us](mailto:Adriana.Rhames@dshs.state.tx.us). ♦



## Prepare Presentations that Work: What are the Seven Steps?

By Kathryn Johnson, Public Information, Education, and Training Group

Recently, I sat at my computer thinking about what I've learned and, as a trainer, what I have taught about "preparing presentations." For years, I've been told there are three parts to a presentation: the introduction, the body, and the conclusion. However, experience has taught me that there are actually seven steps: 1) Preparation and Planning, 2) Introduction, 3) Body, 4) Conclusion, 5) Questions and Answers, 6) Visual Aids, and 7) Practice the delivery of a presentation.

### Step 1 – Preparation and Planning

Preparation is the key to a successful presentation. The average quality one-hour presentation will take eight hours or longer to prepare, excluding graphics or visuals. It is interesting to note, all tasks involving communication start with a presentation. Before giving a presentation, determine the following:

- Why present this topic? – Write a purpose statement that answers the question: what is the purpose of the presentation? Why will the audience want to hear this presentation?
- Who is your target audience? How will they feel about your topic?
- In less than 18 words, what is the main thought, idea, or point that?
- How will you structure or outline your presentation? Label each section with a number or word that tells you where each thought fits into your outline.
- What information will you use to support your main idea, topic, or thought?
- When and where will the presentation be conducted?
- How much presentation time is allotted for your presentation?
- What do I need my audience to do after reading or listening to my presentation?
- How will you encourage audience participation?
- What is the most helpful action in step one? Prepare an outline, which includes the

introduction, body, conclusion, proposed question and answers, and visual aids.

### Step 2 – Introduction

The introduction is the first critical part of your presentation. It lays the foundation for your entire presentation. The introduction provides an overview of the presentation, what you're going to tell them. The introduction also gives the audience the facts necessary to accomplish the goals of the presentation. The four questions to answer:

- What is the overview of this presentation? Give the salient points of the presentation.
  - Why is this topic important? Clarify the purpose of the presentation.
  - How will the audience see and learn? Determine the format that will be used.
  - Who are the presenters? Provide introductions and indicate roles.

#### It is critical to:

- Develop rapport with your audience. Help them help you connect with them.
- Capture your audience's attention by demonstrating that your topic matters to them.
- Start on a genuine note – ask a question, tell a personal story, refer to a local event or a recent event in the news, read a quote, or refer to something that just happened in the

audience.

- Give your audience a "taste" of your topic.
- Outline the structure of the topic for them.

### Step 3 – Body

After the introduction, use the body to develop your ideas. The body is considered the "meat and potatoes" of your presentation. It provides the actual information, details and supporting evidence of your main idea or topic. The body:

- Takes the majority of time in the presentation.
- May have several sections, each directed to the main points. This is where you provide clear relevant examples, figures, facts, case

*Preparation is the key to a successful presentation. The average quality one-hour presentation will take eight hours or longer to prepare.*



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studies, graphs, charts, strong testimonials, and references.

- Provides transitional sections to help the audience stay connected to the presentation, for example “now we’ll move on to the second step in the seven steps.”
- Tells the audience why a particular section is relevant to the presentation.

Makes sure you periodically let your audience know where you are in your presentation.

#### **Step 4 – Conclusion**

End with a concluding statement or invite questions, or both. To end a presentation use words like “in summary,” “in conclusion,” or “finally.” Recap what you have said.

- Review, highlight, and emphasize key points, benefits, and recommendations.
- Draw conclusions – where are we now? What does this mean? What are the next steps?

#### **Step 5 – Questions and Answers**

Questions are an essential part of most presentations. They allow your audience to interact with you, to clarify ideas, or simply to get more information.

In general, ask your audience to hold their questions until the end of your presentation. Often your presentation will answer many of the questions people might otherwise have asked. Tips on preparation:

- Anticipate questions from your audience.
- Prepare answers to likely questions before the presentation, especially the tough ones.
- Prepare to defend any assumptions that you have made.
- Set a time limit for the question period.
- Before finishing the question period, remind people that it is almost over by saying something like “We’re almost out-of-time. I can take one more quick question.”
- If someone is persistent with follow-up questions, tell them you will provide more information after the question period is over.

#### **Step 6 – Visual Aids**

Visual aids include overheads, slides, handouts, models, audio, whiteboards, paper, video clips, and presentation software, like PowerPoint. A few common, and guidelines for preparing visual aids:

- Keep presentations to a minimum. No more than five bullet points per slide. Keep the slide to one core idea.
- Ensure that your audience will be able to read the text. Check the font and contrast size.
- Keep visuals simple, clear, and pertinent.

- Plan which points you want to emphasize and determine which type of visual aid will best allow you to do this.

What are the general tips for using a computer-generated presentation?

- If the computer doesn’t work minutes before the presentation, have an alternate plan, for example, have available flipchart illustrations, whiteboard, and handouts.
- Know the technical options that are available and functioning, like internet access.
- Do the electrical outlets and lights work?
- How are they controlled?
- Is there a projection screen in the room? If so, do you know how to operate it?

Visual Preparation Tips:

- Use color to accelerate learning and recall. Color can enhance learning by 55% and comprehension by 70%. If you plan to use complex ideas, break the image into smaller, less complicated parts.
- Do not show anything that you don’t plan to discuss. Explain graphics that you show.
- Do not talk at your visual aid.
- Direct your presentation toward the audience and refer to your images with a pointer, pen, or pencil. If your hands shake, a pointer, pen, or pencil will help you be steady.
- Make slide presentation easy to see and allow for was change in the order of your presentation.
- Whiteboards and paper are convenient and allow you to be spontaneous and incorporate feedback from the audience.
- Handouts are an excellent accompaniment to any of the visual aid. However, if audience to the handout, instead of listening to you.

#### **Step 7 – Practice Delivering Your Presentation**

- Practice your presentation at least once before delivering it to a “live” audience.
- Practice in the room that you will give the presentation or as similar surroundings as possible.
- Try recording yourself and listening to the tone, pitch, and speed of your voice. Try to sound natural and relaxed.
- Pause naturally as if you were in a conversation.
- Practicing your presentation out loud can help you clarify your ideas and thoughts.
- Add instructions on your note pad or index cards like “slow down”, “speed up”, “look eye-



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to-eye with the audience”, and “look serious, happy, or sad.”

- Warm up with vocal or breathing exercises.
- Take a deep breath before walking to the front of the audience.
- Walk slowly to the front, pause, and look at the audience before speaking. Focus on the audience, not your notes or visual aids.
- Look at the audience and never turn your back to them.
- Change your tone of voice periodically to keep the audience's attention.

In conclusion, use the seven steps in preparing and planning your presentation; anticipate the needs of your audience and fulfill their presentation needs. Start with an introduction that captures your audiences' attention. Keep the body simple, making several connections leading to the main points. In the conclusion, as a result of the presentation, determine what you want the audience to know or do. Allow time for questions and answers. Use visual aids that make and impact. Practice, practice, and practice until you deliver a useful, meaningful presentation that works! ♦

**There are many good resources for those wanting to improve their presentation skills.**

**Kathryn suggests:**

1. “Technical Presentation Skills: a Technical Guide for Better Speaking” by Steven Mandell, January 1994, publisher: Course Technology, Inc. (1560522631)
2. “How to Prepare, Stage, and Deliver Winning Presentations” by Thomas Leech, April 2003, publisher: AMACOM (0814472311)
3. “Presentation Skills workshop: Helping People Create and deliver Great Presentations” by Sherron Bienvenu, December 1999, publisher: AMACOM (0814405185)

*Community Partnerships continued from page 8*

### **McDonald's Joins Effort the Help Raise Immunization Awareness**

By Beletra Atwaters, McDonald's Immunize for Healthy Lives Campaign, and Marilyn Self, Community Council of Greater Dallas

This year marked an unprecedented collaboration between five North Texas health organizations to promote the importance of childhood immunizations.

Collin County, Dallas County, Denton County, and Tarrant County health departments, and Immunize Kids! Dallas Area Partnership collaborated with 285 McDonald's restaurants throughout North Texas to promote awareness about the importance of childhood immunizations. Localized informational materials and public service announcements promoted immunizations through McDonald's *Immunize for Healthy Lives* campaign.

The goal of the campaign is to increase the rates of childhood immunizations to fight vaccine preventable disease.

McDonald's *Immunize for Healthy Lives* campaign is a 13 year-old education and awareness campaign created by McDonald's national partners, the American Academy of Pediatrics and National Association of City and County Health Officials. This is the first year the campaign was implemented in North Texas.

From July 12 through August 12, immunization educational materials, schedules, and incentives were provided to children who received vaccinations. The North Texas outreach effort also included distributing printed materials in local restaurants. More than 850,000 tray liners and more than 570,000 bag stuffers were distributed. Healthcare partners received incentives and campaign fliers for distribution at community events.

Immunize Kids! Dallas Area Partnership is sponsored by the Community Council of Greater Dallas. The coalition is made up of more than 100 members representing service organizations, businesses, and health and human service providers. ♦

# AroundRegions

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## SNS Exercise Gets Green Light

By Cheryl Millican, Region 2/3

Preparations for the August 8<sup>th</sup> and 9<sup>th</sup> exercise began months prior in Region 2/3. The Strategic National Stockpile (SNS) exercise took hundreds of man-hours and utilized staff from three health service regions and multiple state agencies. In conjunction with the DSHS exercise, Dallas, Tarrant, Collin, and Denton County health departments also practiced their own bioterrorism planning.

The state's ability to receive the SNS, a shipment of drugs and medical supplies stockpiled from the Centers for Disease Control and Prevention (CDC) in the event of a bioterrorism event or a national disaster, depended on our efforts during a 24-hour period. Staff were trained by regional and CDC staff in duties ranging from answering telephone calls from the frightened public to shrink wrapping pallets of medical supplies and drugs for shipment to points of distribution (PODs) throughout the affected areas.

The Arlington Regional Command Center (RCC) was activated on August 8<sup>th</sup> with a scenario of pneumonic plague. By 8 p.m. that night, the stockpile had been requested and staff was recalled. RCC staff reported to the regional headquarters where they worked through the night receiving orders from hospitals and other PODs and forwarding them to the Receiving, Staging, and Storing facility (RSS).

At the RSS, 40 large containers of drugs and medical supplies, some weighing as much as 1500 pounds, arrived early on the morning of August 9<sup>th</sup>, where staff was waiting to unload, break down, and repackage supplies for the waiting trucks. CDC personnel estimated that it would take approximately 90 minutes

for staff to unload and stage the containers. Regional staff accomplished it in 36 minutes.

As the night wore on, the evaluators from the Texas Engineering Extension Service who were observing the exercise threw problems at the participants. RCC staff faced the loss of electricity, loss of Internet connections and no phones, while RSS staff dealt with a bomb threat, loss of the automated inventory system, and an issue involving a medication not on a standardized list.

As the exercise wound down at the RCC, Ralph Morris, MD, one of the TEEX observers who also works for the Minnesota Department of Health said, "I wish I could transplant this staff to Minnesota." He said the RCC staff "worked well together and had the ability to adapt to unplanned events." The CDC observer at the RSS said, "this is an excellent group, excellent operation, and they displayed a lot of great teamwork." Commissioner Sanchez responded with an enthusiastic "You guys kicked butt!"



Strategic National Stockpile exercise participants receive instructions at the beginning of the exercise.  
Photo by Linda Williams

James Zoretic, MD, Medical Director for Regions 2/3, later notified the staff via e-mail that DSHS earned a 'green minus' rating from the CDC. The green minus rating means DSHS is ready to receive emergency shipments of vaccine, drugs, and hospital supplies in the event of a mass exposure to an infectious disease in the state. The Community Preparedness section will continue to train local health departments on receiving their shipments. The RCC will continue to be activated to keep staff current on skills and as needed, such as the response to Hurricane Katrina, when the RCC was activated. So, stay tuned because next year the exercise could be in your area. ♦

# New Employee *Corner*

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*Jeanne Jamail ♦ Information Specialist*

*Public Information, Education, and Training Group*



Jeanne began work on September 19<sup>th</sup> as an Information Specialist with PiET. Her responsibilities will include assistance with training coordination, web site coordination and compilation and editing of *The UpShot Online* quarterly newsletter. Before coming to the Department of State Health Services, Jeanne worked as an Information Specialist at Advocacy, Inc. Her position there provided experience in layout and design of all printed and multi-media training materials as well as courtroom presentations, web design, and web site management for both internet and intranet websites, querying the client data base for the purpose of federal report writing data, and production of two online newsletters.

Jeanne serves the community as a member of the Board of Directors for Austin Recovery, a non-profit, alcoholism and drug treatment center. She is also on the Development Committee for the Austin Council on Addiction and Recovery as well as the Austin Recovery Sustainers Council.

She expresses enthusiasm in serving the State of Texas and contributing to our mission: improving the quality and longevity of life for the people of Texas by achieving and maintaining a vaccine-preventable disease-free environment. ♦

*Reuben Parrish ♦ Public Health Technician*

*Operational Support and Compliance*

Reuben tells us: “Before moving to Texas a little more than a year ago, I worked as a Health Education Specialist for the Fresno (CA) County Department of Community Health and was involved in a myriad of coalitions (water safety, asthma, child safety seats, obesity, and tobacco). Before working at DSHS, I was a YMCA afterschool site director in the Round Rock Independent School District promoting and encouraging physical, emotional, and character development in children.



As a Public Health Technician, I respond to inquiries from the Texas Education Agency (TEA), school nurses, physicians, and child care directors and parents on school and child care facilities immunization requirements, exemptions, and reporting. I also process conscientious exemption forms for immunization requirements and monitor compliance with immunization rules and regulations applicable to all schools accredited by TEA.

I recently completed my Master of Public Health degree with a concentration in Health Promotion and Education from California State University, Fresno. In my spare time, I like to spend time with my wife of almost five years, take different dance classes, paint and draw, and train to compete in the 400 intermediate hurdles on a professional level in Track and Field.” ♦

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*Mattie Holley ♦ Public Health Technician*  
*ImmTrac Group*



Hello. My name is Mattie Charlene Holley. I was born and raised in Coffeeville, Mississippi. After high school I met and married a wonderful man by the name of Mark Anthony, who is now and will always be my husband. We've been together for fourteen years and we have three beautiful children together: Marcus our oldest, who is ten years old, Margaret, who is nine years old, and my little princess Michelle, she's six.

We moved to Austin from Alexandria, Virginia, five years ago after ending our Tours of Service with the US Army after eleven years of service. I've traveled all over the world and it truly was a pleasure.

During my travels, I started out as a data entry operator for the southeastern area in the Atlanta and Job Corps Center Dynamic Education Support Systems, Inc. I moved on to being an electric mail barcode operator for Lockheed, Inc., and later as a personnel administrative clerk for the US Army Butzback Medical Health Clinic in Germany. Temporary services allowed me to be with my children and family.

Now I have a great career here with ImmTrac as a Public Health Technician. I receive consent forms, perform client searches, do data quality management, and TWICES. Then I process them into the registry. I am loving it! ♦

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*Katrina Activities, continued from front page*

**Future**

After addressing immediate needs for evacuees and public health workers, intermediate and longer-term strategies were outlined. Increased supplies of vaccine will be needed to address longer-term temporary residents and the evacuees who decide to become permanent Texas residents. Assurance that children and adults are properly immunized and vaccine records are established in Texas and Louisiana will continue. The public health system and infrastructure will be evaluated to ensure Texas can accommodate new permanent residents and provide solutions to any challenges. "The immunization infrastructure is strong in Texas and that infrastructure is key to serving Katrina evacuees for the short-term. We will have to monitor services provided by that infrastructure in the long-term to ensure it has the capacity to serve evacuees that decide to make Texas their permanent home," said Jack Sims, Immunization Branch Manager.

The Immunization Branch employees, health service regions staff, and local health departments staff that comprise the statewide infrastructure responded immediately, professionally, and sympathetically to Hurricane Katrina activities. Our role in the ongoing and day-to-day Hurricane Katrina activities will change as needs change, however, our theme remains HUG, HELP, SERVE, and TRACK. ♦



# Immunization *News Briefs*

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Compiled by Susan Belisle, RN, BSN

## **Direct and Indirect Effects of Routine Vaccination of Children with 7-Valent Pneumococcal Conjugate Vaccine on Incidence of Invasive Pneumococcal Disease — United States, 1998—2003**

Centers for Disease Control and Prevention (CDC)- September 16, 2005. *Streptococcus pneumoniae* (pneumococcus) is a leading cause of pneumonia and meningitis in the US and disproportionately affects young children and the elderly. In 2000, a 7-valent pneumococcal conjugate vaccine (PCV7) was licensed in the US routine use in children aged <5 years. Surveillance data from 2001 and 2002 indicated substantial declines in invasive pneumococcal disease (IPD) in children and adults compared with prevaccine years. This report updates assessment of the impact of PCV7 on IPD through 2003 by using population-based data from the Active Bacterial Core surveillance (ABCs) of the Emerging Infections Program Network, a cooperative surveillance program conducted by several state health departments and CDC. The results of this analysis indicated that 1) routine vaccination of young children with PCV7 continued to result in statistically significant declines in incidence of IPD through 2003 in the age group targeted for vaccination and among older children and adults, 2) the vaccine prevented more than twice as many IPD cases in 2003 through indirect effects on pneumococcal transmission (i.e., herd immunity) than through its direct effect of protecting vaccinated children, and 3) increases in disease caused by pneumococcal serotypes not included in the vaccine (i.e., replacement disease) occurred in certain populations but were small compared with overall declines in vaccine-serotype disease. Ongoing surveillance is needed to assess whether reductions in vaccine-serotype IPD are sustained and whether replacement disease will erode the substantial benefits of routine vaccination. ♦

## **NIAID, MedImmune team up to develop pandemic flu vaccines**

Sep 28, 2005 (CIDRAP News) – The federal government and MedImmune Inc. announced today they will collaborate to develop vaccines for potential pandemic strains of influenza, using the technology that was used to create the company's nasal-spray flu vaccine.

The National Institute of Allergy and Infectious Diseases (NIAID) will work with MedImmune to develop vaccines for many flu virus strains, a project that will take years, according to a Department of Health and Human Services announcement.

The company said in a news release, MedImmune scientists will work together with leading researchers of the NIAID Laboratory of Infectious Diseases to produce and test versions of MedImmune's attenuated, live intranasal influenza vaccine for use against different types of potential pandemic influenza strains, including one based on H5N1, the avian flu strain now endemic in Southeast Asia. NIAID and MedImmune will develop at least one vaccine for each of the 16 different forms of hemagglutinin, a key protein on the surface of flu viruses, HHS officials said. (Hemagglutinin is represented by the H in the names of flu strains, such as H5N1.)

## **Senate approves \$4 billion to prepare for flu pandemic**

Sep 30, 2005 (CIDRAP News) – The US Senate voted yesterday to provide \$4 billion for antiviral drugs and other measures to prepare for a feared influenza pandemic, but whether the measure would clear Congress was uncertain.

The Senate attached the measure to a \$440 billion defense-spending bill for 2006, according to the Associated Press (AP). But the House included no flu money in its version of the defense bill, and a key senator said he would try to keep the funds out of the House-Senate compromise version. The Senate is expected to vote on the overall bill next week.

Almost \$3.1 billion of the money would be used to stockpile the antiviral drug oseltamivir (Tamiflu), and the rest would go for global flu surveillance, development of vaccines, and state and local preparedness, according to a Reuters report. The government currently has enough oseltamivir to treat a few million people, with a goal of acquiring enough to treat 20 million.



# Status of Licensure and Recommendations for New Vaccines-

From Red Book® Online ♦ Updated October 6, 2005

Vaccine	Manufacturer	BLA submitted to the FDA	BLA age indications**	FDA licensure status	Status of AAP/CDC recommendations***
MCV4 (Menactra™)	sanofi pasteur	Dec-03	11-55 years of age	Licensed 14-Jan-05	AAP: <a href="http://aapolicy.aapublications.org/cgi/content/full/pediatrics.116/2/496">aapolicy.aapublications.org/cgi/content/full/pediatrics.116/2/496</a> CDC: <a href="http://www.cdc.gov/mmwr/preview/mmwrhtml/rfs407a1.htm">www.cdc.gov/mmwr/preview/mmwrhtml/rfs407a1.htm</a>
Varicella virus second dose (Varivax®)	Merck	Supplement to original BLA March 2005	2-10 years of age	To be reviewed	Pending FDA licensure
Tdap (Boostrix™)	GlaxoSmithKline (GSK)	Supplement to original BLA: optional second dose	children 12 months to 12 years of age (3 month minimum interval)	Licensed 5-Apr-05	Not Recommended Jun-05
Tdap (ADACEL™)	sanofi pasteur	Jul-04	10-18 years of age	Licensed 3-May-05	ACIP: <a href="http://www.cdc.gov/nip/vaccine/tdap/default.htm">www.cdc.gov/nip/vaccine/tdap/default.htm</a>
MMRV (ProQuad®)	Merck	Aug-04	11-64 years of age	Licensed 10-Jun-05	ACIP: <a href="http://www.cdc.gov/nip/vaccine/tdap/default.htm">www.cdc.gov/nip/vaccine/tdap/default.htm</a>
Hepatitis A (Vaqta®)	Merck	Aug-04	Same as for MMR dose 1 or dose 2; 12 months to 12 years	Licensed 6-Sep-05	Pending review
Hepatitis A (Havrix®)	Merck	Supplement to original BLA	greater than or equal to 12 months	Licensed 15-Aug-05	Pending review
Rotavirus (Rotateq®)	GlaxoSmithKline (GSK)	Supplement to original BLA	greater than or equal to 12 months	Licensed 18-Oct-05	Pending review
Zoster vaccine (Zostavax™)	Merck	Apr-05	2, 4, and 6 months of age	To be reviewed	Pending FDA licensure
Influenza (Fluarix™)	Merck	Apr-05	older adults	To be reviewed	Pending FDA licensure
HPV (Gardasil™)	GlaxoSmithKline (GSK)	25-May-2005	over 18 years of age	Licensed 31-Aug-05	CDC: <a href="http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5434a4.htm">www.cdc.gov/mmwr/preview/mmwrhtml/mm5434a4.htm</a>
HPV (Cervarix™)	Merck	Possible submission 4th Quarter 2005	11-26 years of age (3 doses)	Pending BLA submission	Pending FDA licensure
Hib/DTaP/IPV (Pentacel™)	GlaxoSmithKline (GSK)	TBD	Pending submission	Pending BLA submission	Pending FDA licensure
CAIV-T	sanofi pasteur	25-July-2005	2, 4, 6, and 15 to 18 months	To be reviewed	Pending FDA licensure
	MedImmune	Possible submission 1st Half 2006	6 months to 49 years	Pending BLA submission	Pending FDA licensure

**Table updated 10/19/05- table updated frequently, please refer to <http://aapredbook.aapublications.org/news/vaccstatus.shtml> for updates**

BLA = biologics license application, VRBPAC = Vaccines and Related Biological Products Advisory Committee, FDA = Food and Drug Administration

AAP = American Academy of Pediatrics, ACIP = Advisory Committee on Immunization Practices, MCV4 = Meningococcal conjugate vaccine

MMRV = measles, mumps, rubella, varicella, Tdap = Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, absorbed

HPV = human papillomavirus vaccine, Hib = Haemophilus influenzae b, DTaP = Diphtheria, Tetanus and Pertussis, IPV = Inactivated Poliovirus Vaccine, CAIV-T = Cold adapted influenza vaccine-trivalent

\* information from vaccine manufacturers, from ACIP meetings and from AAP

\*\* age licensure can change following FDA review; not final until package insert approved

\*\*\* ACIP recommendations do not become official until approved by the CDC Director and Department of HHS and publication in MMWR; AAP recommendations do not become official until approved by the Board of Directors

# Peri-Natal Hepatitis B Prevention

By Susan Belisle, RN, BSN

Hepatitis B (HepB) is a potentially cancer causing disease, which can be prevented. It requires everyone to do their part to protect our babies and adolescents. The prevention should start in the pre-natal phase of a woman's pregnancy. If it is not begun there the nursery of the hospital where the baby is born, is where the next steps should be taken. The Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Obstetricians and Gynecologists (ACOG) have made the following recommendations that are contained in this article. For a link to an Immunization Action Coalition article on this topic go to:

<http://www.immunize.org/catg.d/p2130per.pdf> Also see this site for a schedule for parents to refer to for their baby's shots.

This article gives the reader the specifics they need for establishing their own Standing Orders (SO) for their hospital. The SOs are necessary to make sure these policies and procedures are carried out in **all cases**. This is essential because of the timing of the vaccine to be given after the baby is born.

HepB HBsAg Negative Mothers		HepB HBsAg Unknown or Positive	
Labor and Delivery Unit Guidelines			
Upon admission <b>all</b> mother's hepatitis B surface antigen (HbsAg *) lab report should be placed on: 1. The labor and delivery record 2. The infant's delivery record <b>This must be the original lab report.</b>		Upon admission, <b>all</b> mother's HepB surface antigen (HBsAg) lab report should be placed on: 1. The labor and delivery record 2. The infant's delivery record <b>This must be the original lab report.</b>	
		If the HbsAg results are not available, order an HBsAg ASAP. Results must be communicated to the nursery upon completion. 1. Alert the nursery if the mother's HBsAg status is positive or her HbsAg status is unknown. These infants require immunoprophylaxis <b>within 12 hours</b> of birth with HepB vaccine. If the mother is positive, give the infant Hepatitis B Immunoglobulin (HBIG) as well. 2. Make sure that the mother is aware that the infant must receive the vaccine <b>within 12 hours</b> of the infant's birth if her HbsAg is positive or her status is unknown.	
Nursery Unit Guidelines			
Infants born to HbsAg – Negative Mothers		Infants born to Mothers with unknown HbsAg status	
1. Give HepB vaccine prior to discharge from nursery 2. Give the mother an immunization record and ask to always bring it to any appointment the child has with the physician or clinic. 3. Obtain feedback for the mother that she understands the importance of completing the series of HepB vaccine. 4. Making sure the date the vaccine was given is annotated on the record, that it is attached to the hospital record, and that it is sent to the primary care provider.		1. Give HepB vaccine (0.5mL, IM <b>within 12 hours</b> of birth. Do not wait for test results before giving vaccine. (For infants weighing < 2 kg. see special recommendations in item 6 of this section) 2. Provide an immunization record to the mother and make sure she understands the importance of completing the HepB series. 3. Confirm that the lab has drawn a serum specimen from the mother for an HbsAg test and verify when the result will be available and that the results will be reported to the nursery upon completion. If the nursery doesn't receive the report in a timely fashion call and request it. 4. If the mother's result are positive: <ul style="list-style-type: none"><li>Give HBIG (0.5 mL, IM) to the infant ASAP and alert the mother's and infant's physician(s) of the test result. (If 7 days have passed since birth there is no reason to give the HBIG.)</li><li>Follow the instructions in the section Infants born to HbsAg-positive mothers.</li></ul> 5. If infant must be discharged before the HbsAg result is known: <ul style="list-style-type: none"><li>Clearly document how to reach the parents (addresses, telephone numbers, emergency contacts) as well as the infant's primary care provider, in case further treatment is needed.</li><li>Notify the mother's and infant's doctor (s) that the HbsAg results are pending.</li></ul> 6. For infants weighing < 2 kg. Administer HepB vaccine and HBIG <b>within 12 hours</b> of birth but do not count this as the first dose. Initiate the full HepB vaccine series at 1-2 mos. of age	

Nursery Unit Guidelines	
	Infants born to Mothers who are HbsAg Positive
	<ol style="list-style-type: none"> <li>1. Give HBIG 0.5 mL IM and HepB vaccine 0.5 mL at separate sites <b>within 12 hours</b> of birth. * (For infants weighing &lt; 2 kg. see special recommendations in item 7 of this section).</li> <li>2. Give the mother an immunization record card that includes the dates of the HepB vaccine and HBIG, and instruct her to bring this personal record card with her each time her baby sees a provider.</li> <li>3. Encourage mothers inclined to breastfeed to do so, including immediately after delivery, even the infant has not been vaccinated.</li> <li>4. Provide the mother with educational and written materials regarding: <ul style="list-style-type: none"> <li>• The importance of having her baby complete the HepB vaccination schedule on time: <ul style="list-style-type: none"> <li>-Monovalent vaccine 1-2 and 6 mos.</li> <li>-Comvax 2,4, and 12-15 mos.;</li> <li>-Pediarix 2,4,6 mos.)</li> </ul> </li> <li>• The importance of post vaccination testing for the infant following the HepB series to assure immunity;</li> <li>• The mother's need for ongoing medical follow-up for her chronic HBV infection; and,</li> <li>• The importance of testing household members for hepatitis B and then vaccinating if susceptible. Susceptible is defined as those people who have intimate contact with the infected individual. HepB is transmitted by bodily fluids.</li> </ul> </li> <li>5. Notify your local or state health department that the infant has been born and has received post exposure prophylaxis (include dates that HBIG and HepB vaccine were given).</li> <li>6. Obtain the name, address, and phone number of the infant's primary care clinic and doctor. Notify them of the infant's birth, the receipt of post exposure prophylaxis, and the importance of additional on-time vaccination and post vaccination testing.</li> <li>7. For infants weighing &lt;2 kg, administer HepB vaccine and HBIG <b>within 12 hours</b> of birth. Do not count this dose as the first dose. Then initiate the full HepB vaccine series at 1-2 mos. of age.</li> </ol>

**Notes:**

**The Texas Administrative Code (TAC) Title 25 Part 1 Chapter 97 Subchapter F Rule §97.135  
Serological Testing during Pregnancy and delivery:**

The pregnant woman is to be tested for HepB once during her pregnancy and again when she arrives at the hospital to deliver the infant. The lab results are to be a part of her medical record throughout that pregnancy and should also be a part of her file and that of the infant at the hospital.

- \*Be sure you order the correct test, Hepatitis B surface antigen (HBsAg), for your patient.

Do not confuse this test result with any of the following tests:

1. Anti-HBs or HBsAb = antibody to hepatitis B surface antigen
2. Anti-HBc or HBcAb = antibody to hepatitis B core antigen

- Be sure you include a copy of the original lab report with the labor and delivery record and that a copy is placed in the newborn's chart.
- §Federal law requires that you give parents a HepB Vaccine Information Statement (VIS) prior to vaccine administration. To obtain VISs, download them from IAC's website at: [www.immunize.org/vis](http://www.immunize.org/vis) or call the CDC-Info Contact Center at (800)232-4636 [(800) CDC-INFO] or call your state health department.

# What you need to know about: **Respiratory Syncytial Virus (RSV)**

## **What is respiratory syncytial virus (RSV)? What does RSV cause?**

RSV is a lung infection caused by a virus. Although it can affect anyone, RSV is the most frequent cause of lower respiratory tract infections in infants and young children. Each year about 125,000 infants are hospitalized with RSV in the United States.

## **What are the symptoms of an RSV infection?**

Many persons with RSV infection show no symptoms. In adults and children older than 3 years, the illness typically begins with a low-grade fever, runny nose, cough, and, sometimes, wheezing. In children younger than age 3, RSV can cause a lower respiratory tract illness, such as bronchiolitis or pneumonia, and more severe cases can result in respiratory failure. Symptoms may include a worsening croupy cough, unusually rapid breathing, difficulty breathing (the chest may suck in with each breath), and a bluish color of the lips or fingernails. RSV has also been found to be a frequent cause of middle ear infections (otitis media) in preschool children.

## **How common is RSV?**

RSV infections occur all over the world, most often in outbreaks that can last up to 5 months, from late fall through early spring. RSV epidemics spread easily in households, daycare centers, and schools.

## **Who is likely to get RSV?**

Most children are infected at least once by age 2 and continue to be reinfected throughout life. RSV is the most common cause of bronchiolitis and pneumonia in infants and children under the age of one. The elderly and premature babies or those with lung or heart problems or with weak immune systems have an especially high risk. Those who are exposed to tobacco smoke, attend daycare, live in crowded conditions, or have school-aged siblings could also be at higher risk.

## **How is RSV spread?**

Typically a parent, or more likely an older sibling, comes down with what seems like a bad cold first. The virus is found in discharges from the nose and throat of an infected person. People can get RSV infection by breathing in droplets after an infected person has coughed; by hand-to-mouth contact after touching an infected person or after touching a surface that an infected person has touched or coughed on. The time period from exposure to illness is usually about 4 days. After an infection, a person may be still contagious for a week.

## **How can you prevent RSV?**

Wash your hands often. Do not touch your eyes, nose, or mouth without washing your hands first. Soap and water and disinfectants easily inactivate the virus.

If possible, avoid exposure to sick persons. Parents with high-risk young infants should avoid crowds.

When RSV infects a daycare center, usually most, if not all of the children come down with an RSV infection. Make sure that all children and employees use good handwashing techniques and that all children and employees cover their faces when coughing or sneezing. Used tissues should be thrown away in a lined trash can immediately after use.

It is important that infants do not share toys, bottles, etc. Surfaces and toys shared by two or more children should be cleaned and disinfected regularly.

Whenever a school-age child comes down with a cold, keep the child away from an infant brother or sister until the symptoms pass.

## **What do I do if I think anyone in my family has RSV?**

Consult with your healthcare provider. Any breathing difficulties in an infant should be considered an emergency, so seek immediate help.

## **How are RSV infections diagnosed?**

The diagnosis is usually made by the pattern of a child's symptoms (a clinical diagnosis), especially if he or she has a cold and is wheezing. RSV can be confirmed by checking for the virus in nasal washings or nasal swabs.

## **How are RSV infections treated?**

There is currently no vaccine to prevent RSV infection. Because RSV infection is often resolved on its own, treatment of mild symptoms is not necessary for most people. For babies and children who are at high risk of developing severe RSV, preventive medication is available. Parents of an infant who is premature, has a serious heart or lung disease, or has a weak immune system should contact their doctor or healthcare provider.

**Who can I call for more information?** You may call Stacy Davlin at the Department of State Health Services at (512) 458-7676, extension 6364.



# Pass the *Word*:

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The *UpShot Online* is your best source of information about the Department of State Health Services Immunization Branch services and programs, and events. Want to be included in the *UpShot* mailing list? Send us your e-mail address and we will notify you when the next issue is posted. ♦

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